ADVANCE CHIROPRACTIC CLINIC

PHONE: 907-562-2802

FAX: 907-562-7667

510 W TUDOR RD

ANCHORAGE, AK 99503

CONFIDENTIAL PATIENT INTAKE FORM

DATE:		AGE:			
NAME:			GENDER:		
First Middle	Last				
MAILING ADDRESS:		CITY:		ST:	ZIP:
RESIDENTIAL ADDRESS		CITY:		ST:	ZIP:
BIRTHDATE:	SSN:				
EMAIL ADDRESS:					
PRIMARY PHONE:	(HOME) (CELL) SECON	DARY PHONE:		·	(HOME) (CELL)
EMPLOYER:	OCCUP	ATION:			
MARITAL STATUS:	# OF CHILDREN:				
EMERGENCY CONTACT:	PHON	VE:		RELATI	ON:
WHOM MAY WE THANK FOR REFFERING	G YOU?				
SYMPTOMS:					
WHEN DID SYMPTOMS APPEAR?					
HAVE YOU HAD PREVIOUS CHIROPRACT		OCTOR?			
SURGERIES:					
BROKEN BONES:					
MAJOR ACCIDENTS/INJURIES:					
MEDICATIONS/SUPPLEMENTS:					

PLEASE COMPLETE THE BACK SIDE OF THIS FORM